

**Building a Coordinated Response to Offender Substance Abuse:  
The Work of the Nebraska Substance Abuse Treatment Task Force**

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**Submitted By:**

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## **Building a Coordinated Response to Offender Substance Abuse: The Work of the Nebraska Substance Abuse Treatment Task Force**

### **Summary of Testimony**

In 1999, the Nebraska Legislature passed LB 865, which required the Governor to appoint a Substance Abuse Task Force to examine the need for and access to substance abuse treatment within the criminal and juvenile justice systems. Specifically, the Task Force was required to accomplish the following ten tasks:

1. Examine the extent of substance abuse within the criminal justice system
2. Examine funding allocations for substance abuse treatment
3. Identify gaps in the criminal justice system that apply to substance abuse
4. Identify criminogenic needs
5. Develop a criminal justice continuum of care
6. Identify treatment modalities to target populations for the most effective outcome
7. Develop a model for the future development of substance abuse services within the criminal justice system
8. Examine the need for a management information services system
9. Identify the need for formal initiatives or agreements between the substance abuse system and the criminal justice system
10. Develop and recommend standardized substance abuse evaluations and assessment instruments.

The Task Force documented its work in a final report issued to the Legislature and Governor in January 2000 (see Attachment A for a summary of this work). In sum, it was clear to Task Force members that (1) substance abuse treatment was an effective way to enhance public safety; (2) the current availability of appropriate treatment was not adequate to address the need among offenders; (3) identifying offenders who need treatment was inconsistent in process and quality; (4) access to services was fragmented and inefficient; and (4) treatment resources were often not available to justice agencies.

The Task Force concluded that enhancing public safety required the implementation of a standardized process that would serve as an infrastructure to enhance system consistency and accuracy and facilitate the coordination of services. Consequently, the Task Force continued its work to develop the Standardized Model for Offender Substance Abuse Assessment. The purpose of this written testimony is to provide the Little Hoover Commission with an overview of the Standardized Model and to relate this work to California initiatives.

## Background

The impetus for LB 865 was generated by a “grassroots” effort initiated by several criminal justice professionals in 1995. These professionals began meeting informally to document the problems related to identifying substance abuse among offenders and accessing appropriate treatment care. Eventually, this group named themselves the Criminal Justice Coordinated Response Team and developed a mission statement, goals, and an informative power point presentation. CJCRT then used their presentation to increase awareness among Nebraska State Senators. Their strategy was productive. Several Senators, led by Senator Nancy Thompson, agreed to introduce and support LB 865 in the 1999 Legislative Session. The bill was passed, and the Governor subsequently appointed the Task Force (see Attachment B for a list of the members).

The Substance Abuse Task Force began meeting in September 1999 under the direction of Kathy Seacrest, LMHP, CADAC. The group sought technical assistance from Denise Herz, Ph.D., at the University of Nebraska—Omaha, Department of Criminal Justice and started working on the ten tasks listed in LB 865. In addressing each of the tasks, the Task Force recognized the need to create a process that would serve as an infrastructure to enhance system consistency and accuracy and to facilitate the coordination of services in the short-term and long-term.

Since the creation of a standardized process that required special attention and more input, the Task Force formed the Standardization Subcommittee to devote complete attention to the task. Task Force member Ellen Fabian Brokofsky, Chief Probation Officer in Sarpy County and Subcommittee Chair, sent letters out to over 75 providers and criminal justice professionals asking them to participate in this effort. The first meeting attracted over 40 providers and criminal justice professionals who voluntarily agreed to participate in this effort. In addition, representatives from the Office of Mental Health and Substance Abuse played significant roles in this process. Table 1 documents the progress of this effort.

**Table 1: Summary of Standardized Model Development**

Date	Activity
1995	Criminal Justice Coordinated Response Team forms
Spring 1998	CJCRT Presents slideshow to State Senators
Spring 1999	State Senators introduce and support LB 865
Spring 1999	LB 865 is passed
September 1999	Task Force work begins
October 1999	Standardization Subcommittee meets
December 1999	Basic design and structure of Standardized Model is created

January 2000	Report submitted to Governor and Legislature
February 2000- December 2001	Task Force approves Model and presents to various key stakeholder groups, including the Governor, agency heads, and judges; Juvenile Drug Courts use portions of the Standardized Model in their screening process
February 2000- June 2002	Standardization Subcommittee finalizes Model and works on implementation protocol
January 2001- June 2002	UNO develops training manual and presentation materials
July-August 2002	Trainings on Standard Model held in Omaha, Lincoln, and North Platte
September 2002- Present	Standardized Model is implemented in limited areas and Office of Mental Health, Substance Abuse, and Addiction Services holds training sessions for required evaluation tools
January 2003- Present	Governor-appointed group formed to determine how and who will oversee statewide implementation of the Standardized Model
January 2004	Statewide implementation of the Standardized Model

As shown in this table, work on the Standardized Model began in October 1999 and included not only development activities but also a number of presentations to key stakeholders and policymakers. The activities listed in this table increased the support for the Standardized Model from key stakeholders internal and external to the planning process.

### **Description of Standardized Model**

The first step in the development of the Standardized Model was to identify how the system currently identified substance abuse and accessed treatment for adult and juvenile offenders. The second step was to identify how an ideal system would operate. The third, and most imposing, step was to create a process that would move the current system toward the ideal system and meet the following goals:

1. To ensure that all offenders are consistently and accurately screened and evaluated (when necessary) for substance abuse/dependency.
2. To coordinate & formalize information sharing across justice and substance abuse professionals.
3. To integrate levels of treatment care with offender accountability.

In creating the Standardized Model, subcommittee members agreed that all justice agencies, adult and juvenile, should use utilize the same process to identify which offenders need substance abuse treatment and what level of treatment care he/she needs.

Subcommittee members stressed the importance of incorporating offender “risk” into substance abuse evaluations and integrating appropriate levels of accountability and appropriate levels of treatment care. Incorporating offender “risk” requires sharing risk related information with providers and ensuring collateral contact with justice personnel to verify the offender’s information and increase the accuracy of the substance abuse evaluation. Integrating accountability and treatment requires the coordination of dual system responses at appropriate levels rather than rely on one system (i.e., treatment) to address the whole problem.

The Standardized Model is comprised of three integrated stages (see Attachment C for a visual description of these stages). The first stage in this process is to *screen* all offenders for substance abuse as early in the process as possible (see Figure 1). The purpose of screening is to determine the presence of a current substance abuse problem and identify the need for further evaluation. The tool selected for this stage of the Model was the Simple Screening Instrument (SSI), which was developed by a Center for Substance Abuse Treatment workgroup. Criminal and juvenile justice agencies are responsible for administering the SSI. Next, offenders who score in the SSI problem area are referred for a further evaluation by a substance abuse professional. Ideally, the justice agency referring the offender will complete a risk assessment prior to the substance abuse evaluation. The purpose of *risk assessment* is to ensure that justice agencies consistently share relevant information on offenders’ prior history and risk levels to evaluators. Currently, justice agencies utilize different risk assessment tools. Until these tools are standardized across agencies, the Model requires the referring justice agency to complete a Standardized Risk Assessment for Substance Abusing Offenders Reporting Form to summarize the information collected from adult and juvenile justice agency risk assessment tools. This form in turn is provided (through court order or release signature) to the substance abuse provider conducting the evaluation.

Finally, the Model stipulates that substance abuse professionals complete a *substance abuse evaluation*. The purpose of the substance abuse evaluation component of the Model is to ensure consistent and accurate diagnoses and treatment recommendations. All substance abuse evaluations for offenders must include the Addiction Severity Index for adults or the Comprehensive Adolescent Severity Inventory (CASI) for juveniles, one additional tool of the provider’s choice, and the completion of the Standardized Substance Abuse Evaluation Reporting Format. The standardized reporting format ensures that the evaluation is (1) reflective of professional standards and “best practices,” (2) comprehensive, and (3) consistent in terminology. These requirements are intended to supplement the evaluators’ professional experience rather than dictate it. If the risk assessment is not completed prior to the evaluation, the Model also requires that the evaluator review the completed risk form and modify his/her evaluations before submitting the final report to the court.

As part of the standardized reporting format for evaluations, a group of subcommittee members developed standardized level of care terminology for substance abuse treatment. This terminology was based on a crosswalk of terms used by all justice agencies and behavioral health oversight agencies. The creation of standardized terminology represented a significant step in getting all decision-makers and providers “on the same page” within and between jurisdictions across the state.

The subcommittee also built accountability into the model by requiring the following:

- “Approved providers” (i.e., certified drug abuse counselors) are required to complete the substance abuse evaluation for justice clients;
- Both criminal justice personnel and approved providers must be certified on the Standardized Model;
- Approved providers must be certified on the required evaluation instruments;
- Local criminal justice agencies and approved providers must sign a formal agreement regarding information sharing; and
- Approved providers must take continuing education credits on criminal justice.

It is important to note that the Standardized Model does not incorporate mental health problems in its current form. Although the Task Force acknowledged mental health problems, addressing this issue was beyond the resources and time available to the group. The Standardized Model, however, was designed with mental health problems in mind, and the Model has been connected to recent documents and recommendations related to addressing mental health problems within the juvenile justice system (see <http://www.nol.org/home/crimecom/Documents.htm> for a copy of Herz and Poland, 2002 Mental Health Report). As such, it is possible (and strongly encouraged) to incorporate similar standards and processes for the identification of mental health disorders and access to appropriate treatment.

### **Current Status of the Standardized Model**

To date, over 500 justice and treatment professionals have been trained on the Standardized Model, and implementation has voluntarily occurred throughout the state (see *Impact of Standardized Model* below). Full implementation is tentatively scheduled for January 1, 2004 following the development of plans for oversight and on-going training which are “under construction” by a new Governor-appointed group.

### **Implementation of the Model**

#### Training

With the help of the Nebraska Crime Commission, funds were provided to contract with faculty from the University of Nebraska—Omaha, Department of Public Administration (Alice Schumaker, Ph.D. and Ethel Williams, Ph.D.) to develop a training manual. In August 2002, over 500 treatment providers and justice personnel were trained on the Standardized Model in three locations (Omaha, Lincoln, and North Platte) across Nebraska. Shortly after the Standardized Model training, Barbara Thomas and Linda Witnesses from the Office of Mental Health and Substance Abuse coordinated and offered a number of trainings to providers on the required evaluation tools (i.e., the Addiction Severity Index and the Comprehensive Adolescent Screening Inventory).

### Information Technology

There is no equipment, technology or software required to implement the Standardized Model, but technology and software potentially make implementation of the Model more efficient and effective. For instance, the results of the screening and risk assessment tools can be integrated into State-based information systems. This would facilitate communication and collaboration across agencies as well as expedite the case, connecting an offender to an appropriate level of care as soon as possible.

The tools required for evaluation (i.e., the Addiction Severity Index for adults and the Comprehensive Adolescent Severity Inventory for juveniles) are both automated. The software for the ASI is free, but the software for the CASI is proprietary. It is unclear whether the state will provide or require automated versions of the evaluation tools. Although preferable for information management, the cost may initially be prohibitive.

### Cost

Overall, the startup costs for the Standardized Model were minimal. Subcommittee members' time was contributed and the technical assistance cost was relatively small because much of the time was contributed in-kind. Training for the Standardized Model cost approximately \$27,500, which paid for the creation of a training manual and presentation, conference costs, and training materials. The cost for future training is expected to be nominal because the manual and certification can be web-based. Additionally, trainings for the required evaluation tools have cost approximately \$50,000.

Some costs are still unknown. One cost involves the creation of the web-based training program for the Standardized Model and adding data elements to the current State-based information system. Once these costs are incurred, the ongoing costs related to maintenance will be substantially less. Costs related to information system maintenance, oversight of the Model, and evaluation of the Model are also expected. Although there is no cost related to the instruments themselves, it seems reasonable to expect criminal justice agencies and providers will incur some personnel expenses. The amount of this expense, however, is difficult to estimate because most of the Standardized Model requirements can be absorbed into current time expenditures.

### **Impact of Standardized Model**

Task Force members were diligent in their efforts to integrate the Standardized Model into other developments in criminal and juvenile justice. The role and contribution of the Standardized Model is summarized below:

- Three juvenile drug courts have used the Model's screening tool to consistently determine eligibility for participation in drug court, enhancing equal access to and appropriate placements in the program.
- Ten out of 15 probation districts statewide are voluntarily implementing the Model and working with providers to create formalized information sharing and partnerships.

- Creation of the Standardized Model contributed to the decision to pilot test the Youth Level of Service Inventory Risk/Needs Assessment Tool for administration in both Juvenile Probation and the Office of Juvenile Services. These two agencies have never coordinated assessment processes in the past. Formal adoption of this tool will contribute to the implementation of the Standardized Model in the juvenile justice system.
- Presentation of the Model to judges has motivated them to ask for standardized reporting and higher standards in report content.
- Implementation of the Model has led Medicaid to examine how the Model would fit into its approval procedures for the provision of treatment to juvenile offenders.
- A general increased awareness has occurred across the state of the attempt to improve the quality of substance abuse services for both the justice system and general population.

### **Relevance for California**

In general, implementation of the Standardized Model is advantageous to any state that attempts to improve its response to substance abuse among offenders. For example, the use of the Standardized Model,

1. Provides the opportunity and an infrastructure for a state to document the need for substance abuse treatment among offenders, the availability of appropriate treatment for offenders, and the impact of treatment on offender recidivism;
2. Provides an infrastructure and the information necessary to develop a continuum of care that integrates appropriate levels of accountability (i.e., supervision levels in the community and/or corrections) with appropriate levels of treatment care (i.e., education to inpatient);
3. Provides an infrastructure that encourages agencies and systems to use the same language in order to increase the equity, consistency, and accuracy with which services are provided to offenders;
4. Provides the criteria to hold justice agencies and treatment providers accountable;
5. Moves policy beyond whether treatment works to why and how it works;
6. Improves the systems ability to ensure the integrity and availability of effective treatment; and,
7. Provides the opportunity for systems and agencies to build partnerships through compromise, agreement, and cross training.

I believe that these advantages have specific application to several California initiatives including, but not limited to, findings and recommendations contained in the *For Our Health and Safety: Joining Forces to Defeat Addiction* Report, Proposition 36, drug courts, and the role of treatment within the juvenile justice system. It is not necessary for California to adopt Nebraska's Standardized Model; however, it is advantageous for California to develop and implement a similar standardized process throughout the state. Below I illustrate how such a process would contribute to initiatives currently underway in California.

*For Our Health and Safety: Joining Forces to Defeat Addiction Report*

The advantages of developing and implementing a standardized process are clear when one considers the findings and recommendations contained in this report. Specifically, a standardized process would help address the following problems:

Finding 1: The State's efforts to reduce alcohol and drug abuse through prevention, treatment and law enforcement programs are fragmented and not focused on cost-effectively curtailing the expense and misery of abuse and addiction in California.

Finding 3: The State has not structured substance abuse treatment programs to provide a statewide basic level of quality or encourage continuous quality improvement.

Finding 4: To be effective, substance abuse treatment must be coordinated and integrated with other social services to effectively reduce the social and financial costs of alcohol and drug abuse.

As illustrated above, Nebraska's primary purpose for creating the Standardized Model was to eliminate fragmentation within and across criminal justice and substance abuse systems and to increase the efficiency and effectiveness of substance abuse treatment for offenders. A standardized process establishes the minimum standards of care required by the state, which creates an effective mechanism to hold all agencies and programming accountable. Finally and perhaps most importantly, it provides a method by which to standardize terminology and eliminate unnecessary duplication across agencies. In other words, the standardized process provides a common denominator from which to build consistency and to coordinate services within and across agencies.

Proposition 36

Proposition 36 requires offenders to submit to a substance abuse evaluation and requires treatment providers to prepare and return a treatment plan to probation within 30 days. Additionally, the treatment provider must prepare progress reports for offenders on a quarterly basis. A standardized process could ensure consistent quality and also augment this process by requiring that the offender be placed in an appropriate level of care that incorporated the offender's risk level. Treatment only works if it is matched to an offender's level of treatment need, and the likelihood of appropriateness is enhanced if the offender's risk level is considered as well. The Standardized Model provides a way to structure information, facilitating information-sharing and accountability and increasing the State's ability to evaluate the effectiveness of the policy.

Drug Courts

Drug courts could benefit from a standardized process in a similar way. Drug courts must select participants based on eligibility criteria. Unfortunately, the selection process often varies across courts and results in subjective decision-making. This poses a problem to effective programming in at least two ways. First, selected participants may be inappropriate for the program and set the program up to fail, and secondly, not everyone is given equal access to the program. A standardized process used for assessing substance abuse/dependency and risk levels provides a method by which all drug courts operate. Using a standardized process, the eligibility criteria may differ across courts, but the information upon which those criteria are based would be the same in quality and content across all offenders. Additionally, appropriate programming can be identified for those who are ineligible for the drug court; thus, the standardized process becomes the foundation for a continuum of care that integrates supervision and treatment.

### Juvenile Justice

Rehabilitation and punishment are often viewed as conflicting goals of the juvenile justice system. By using a standardized process and viewing punishment in terms of accountability rather than punishment, juvenile justice has the opportunity to document the risk and need levels of its offenders and build interventions to address both simultaneously.

### **Conclusion**

The Standardized Model has evolved since its inception. The original idea was to simply rethink the process by which substance abuse was identified and treated within the criminal justice system. Not only did the Task Force accomplish this task, it incorporated as many justice and treatment “best practices” as possible and became a program focused on improving the justice system and building bridges between treatment and justice professionals. The process of developing the Standardized Model was built on partnerships—it was created by justice professionals and treatment providers working together to resolve conflicts and establish common ground. Furthermore, the Model was not created by agency administrators and handed down; rather, it was created by individuals dealing with these problems on a daily basis and handed up to administrators. It represents a “cutting edge” response to problems that have plagued criminal justice systems for decades, and it reflects solutions that are practical and feasible.

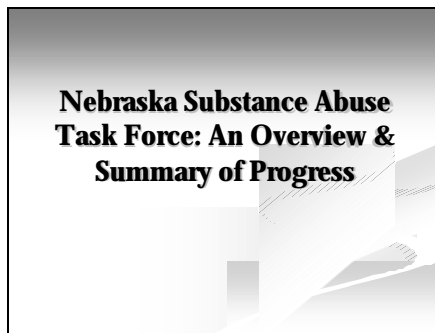
The key to Nebraska’s success with the Standardized Model rests in the combination of vision, leadership, commitment, and openness. Any state that attempts to create a Standardized Model process will need to clearly understand and accept the problems that face the criminal justice system overall and with regard to substance abuse. A state must have a person or group of persons who understand (1) how these problems can be addressed; (2) who the key stakeholders are, and (3) how to “get the ball rolling.” Once the ball is rolling, it is critical to tap into a variety of resources. It is important to bring justice, treatment, and research expertise together to form a solution. Those involved must be committed at a level that view setbacks as temporary and focus on moments of success, no matter how small, as evidence that things can change. Developing a solution requires the inclusion of all interested parties. By opening this process, conflict is dealt

with in the beginning and used as a foundation for investment. Identifying and addressing conflicts in the beginning builds consensus in the long-run and avoids hidden pitfalls in the end. Including everyone, however, requires strong leadership. It requires a leader who can find compromise, maintain the integrity of the process, facilitate the creation of substantive products, and keep the agenda moving forward.

Politics, personalities, and hidden agendas are often the largest obstacles to successful change, and each state should be prepared to deal with these factors. Progress is stagnated if there is no consensus on the need to address substance abuse among offenders. With consensus, the mandate becomes clear. To improve public safety, the justice system must effectively address offender substance abuse. To effectively address offender substance abuse, the need for treatment must be identified accurately and an appropriate level of supervision and treatment must be integrated and given to the offender. The only way to accomplish this is to institute a fair and equitable process that will provide consistent and accurate information and to facilitate cross-discipline education that will build partnerships and information bridges between justice personnel and treatment providers.

## Attachment A

Slide 1



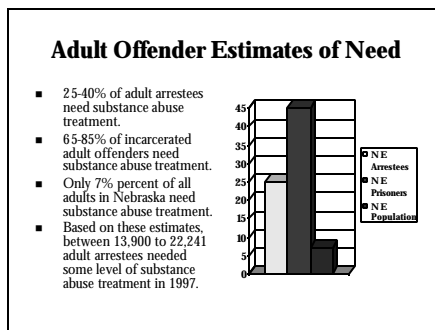
### Nebraska Substance Abuse Task Force: An Overview & Summary of Progress

Slide 2

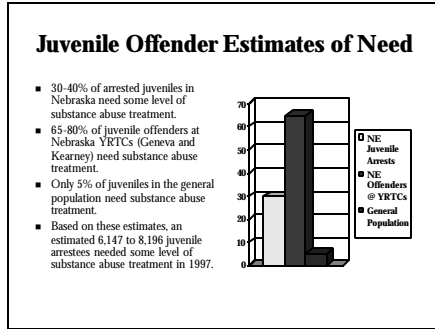
**Summary of T/F Work: 1999-2000**

- **T/F Vision:** Nebraska communities are safe, healthy, and free of substance abuse.
- **T/F Mission:** Enhance public safety and reduce criminal behavior by ensuring all governmental entities responsible for supervising individuals in the adult and juvenile justice systems have knowledge of and equal access to a full continuum of effective substance abuse services.

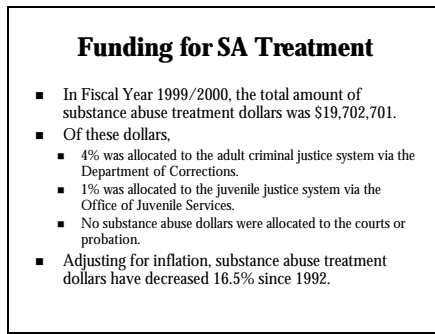
Slide 3



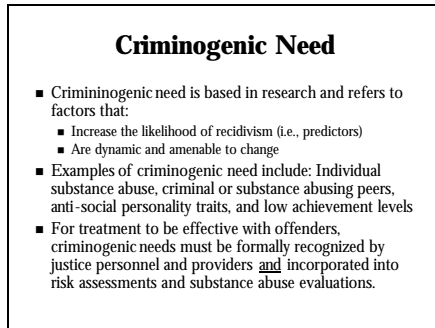
Slide 4



Slide 5



Slide 6



Slide 7

**Effectiveness of Treatment**

- Treatment of addiction is as successful as the treatment of other chronic diseases such as diabetes, hypertension, and asthma as long as treatment “best practices” are implemented (NIDA, 1999).
- It is estimated that for every \$1 spent on treatment, there is a \$4-\$7 reduction in drug –related crime and criminal justice costs (CALDATA Study, 1994).
- Coerced treatment works—Sanctions or enticements from the criminal justice system can significantly increase treatment entry, retention rates and the success of drug treatment interventions.

Slide 8

**Treatment “Best Practices”**

- Matching treatment settings, interventions, and services to individual needs.
- Addressing multiple needs (e.g., medical, psychological, social, and criminogenic), not just substance use.
- Inclusion of counseling and other behavioral modification therapies.
- Recognition of relapse and viewing drug addiction as a long-term process.

Slide 9

**Gaps in the CJ/SA Provider Relationship**

- Inconsistent coordination and communication
  - Lack of cross-training
  - Lack of information sharing
- Lack of criteria and accountability
  - Selecting offenders for evaluations (Justice)
  - Producing quality evaluations (Providers)
- Need to reexamine and update treatment approaches for offenders
- Lack of system resources to pay for treatment
- Lack of treatment & Certified Alcohol/Drug Abuse Counselors
  - 1 CADAC/3,068 NE Residents
  - 1 CADAC/12,500 Western NE Residents

Slide 10

**Summary of T/F Work: 2000-01**

- Recommendations
  - 38 recommendations listed in the 2000 Report
  - Work was completed on 25 (66%) of these recommendations by the T/F, justice agencies and programs, the Division of MH/SA, the NE U.S. Attorney's Office, and other governmental units
- Standardization Subcommittee
- Risk Assessment Subcommittee
- Training Subcommittee

Slide 11

**Training Curriculum Progress**

- Identified current agency training in this area
- Obtained agency commitment to use cross-training curricula within current agency training
- Developed cross-training curriculum outline and resources with assistance from the Lincoln Medical Education Foundation
- Worked with the Division of Mental Health & Substance Abuse to integrate cross-training concept into 2001 Annual Conference

Slide 12

**Modules for Justice**

- Accessing Health and Human Services and Substance Abuse Services
- Basic Knowledge of Addictions
- Values, Attitudes and Beliefs about Drug Users: Confronting the Myths
- Risks Associated with Drug Use

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**Modules for Providers**

- ❑ Relationship between Treatment and Sentencing
- ❑ Overview of Nebraska's Criminal and Juvenile Justice Systems
- ❑ Personality Development and Addictions
- ❑ Best Practices for Offenders

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**Modules for Justice & Providers**

- ❑ Working Collaboratively: Partnerships between Substance Abuse Treatment & the Justice System
- ❑ Screening, Assessment, and Evaluation
- ❑ Mental Health Issues
- ❑ Criminogenic Need, Treatment Plans, and Public Safety
- ❑ Levels of Care: Integrating Levels of Treatment and Graduated Sanctions

## **Attachment B**

### **Appointed Task Force Members**

Kathy Seacrest, Chair, Region II, Service Provider  
Ellen Fabian Brokofsky, Nebraska State Probation Administration  
Deborah Carey- Minardi, Nebraska State Probation Administration  
Kristin Crawford, Governor's Policy Research Office  
Allen Curtis, Nebraska Crime Commission  
Cathy Gibson-Beltz, Department of Corrections  
George Hanigan, Health and Human Services, Office of Mental Health and Substance  
Chris Hanus, Health and Human Services, Office of Protection & Safety  
John Hilgert, Nebraska State Senator  
Linda Krutz, Parole Board  
Dennis P. Marks, Sarpy County Public Defender  
Eric McMasters, Diversion Services-Lincoln, Nebraska  
Dwite Pedersen, Nebraska State Senator  
Steve Rowoldt, Nebraska State Probation Administration  
William J. Schnackenberg, Nebraska Department of Corrections  
Annie L. Scott, Omaha Public Schools, School Principal  
Edward Slips, Nebraska Parole Administration  
Nancy Thompson, Nebraska State Senator  
Gordon Tush, Health and Human Services, Office of Mental Health and Substance Abuse  
Cathy Waller-Borovac, Nebraska Department of Corrections  
Michael Wellman, Nebraska U.S. Attorneys' Office

## Attachment C

# Standardized Model Components

Component	Purpose	What & When
Screening (Justice)	To determine the presence of a current substance abuse problem and identify the need for further evaluation.	Simple Screening Instrument @ Jails, Detention Facilities, Diversion, Drug Treatment Courts, Probation, Corrections, Office of Juvenile Services
Risk Assessment (Justice)	To ensure that justice agencies consistently provide relevant risk information on offender to evaluators.	Standardized Risk Assessment Form completed using agency risk tool for all offenders sent for an evaluation (NOTE: This may be completed after the evaluation and used to update recommendations)
Evaluation (Providers)	To ensure consistent and accurate diagnoses and recommendations for treatment & formalize information sharing.	Addiction Severity Index (Adults) Comp. Adol. Severity Inventory (Juveniles) One Additional Tool (Provider's Choice) Standardized Reporting Format